coming so popular is because hospitals are not meeting all the needs of their patients.

Hospital chaplains have been shown to improve the well-being of hospital patients. Studies have shown that patients do not generally ask for a chaplain when they are sick; however, when one is provided they are grateful that the service is provided. The patient's satisfaction is what the hospital is after and the cost in this case is minimal. Spiritual counseling improves the health of patients and staff. It improves the relationship among hospital staff, patient and physician. Modern medicine should improve the care of spiritual health and should utilize hospital chaplains in doing so.

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Costs of Cardiopulmonary Resuscitation

TO THE EDITOR: The October 1979 issue contained the article "Cardiopulmonary Resuscitation in a University Hospital" [West J Med 131:344-348] by Drs. Hahn, Hutchinson and Conte.

In calculating the costs of cardiopulmonary resuscitation it would be more reasonable and informative to include the cost of care beyond the time of resuscitation for the 81 percent who failed to survive to discharge. It would be interesting and valuable if Dr. Hahn and co-workers could review their cases and determine those costs. Whatever the costs might be, they might well be considered modest in relation to result.

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PSRO: Views of an Anti-PSRO Physician

TO THE EDITOR: In the November 1979 issue, Dr. Alan R. Nelson ("Perceptions on PSRO") and Dr. Paul J. Sanazaro ("PSRO, Politics and Quality Assurance") discuss the current status of the Professional Standards Review Organization (PSRO) program. Briefly, the doctors conclude that physician members of a PSRO find themselves positioned as judges of their colleagues' practice of medicine in terms of controlling cost instead of controlling quality. Further, in the process, they are intervening intimately in the practice of medicine; that is, they are telling a physician what service he may or may not offer his patient on pain of no payment to physician or hospital.

Despite their complaint about the PSRO program, Drs. Nelson and Sanazaro urge physician members to continue with it. This advice stems from their belief that the PSRO is the sole area in which future regulation of health care may be influenced by practicing physicians. Dr. Sanazaro goes even farther and advises that government is now in permanent partnership with physicians and hospitals in "quality assessment and quality assurance." This advice, to continue support of the PSRO despite its evolution contrary to initial hopes, is debatable. I think the problem arises from undefined concepts, from premises which are not a priori, and from logic paths that do not inexorably follow.

Let me start first with the undefined concepts. The big one here is quality. Can a practicing physician tell me what *quality care* is as it relates to individual patients? Is it the demand that a patient be seen in the office, or handling a complaint on the telephone? Is it prescribing antibiotics for a patient with an upper respiratory infection, or getting a throat culture first? Is it early or late admission to hospital for a patient with a suspected myocardial infarction? Is it an austere or a rich use of the hospital laboratory service? Is it four days or six days in hospital after a prostatectomy? Is it alternative birth centers? Is it a coronary bypass procedure on a 78-year-old otherwise in good health? Is it a procedure on a 78-year-old with a transient ischemic attack? With one stroke? Is it the overall mortality and morbidity record of a practitioner, or is it the neatness of his hospital records? After the PSRO has defined quality, perhaps it could define "overutilization," "underutilization," and even "fraud and abuse."

Second, the premises on which the PSRO legislation was conceived and authorized are not a priori. These premises assume partnerships that do not exist, such as between doctors and hospitals. They presume coinciding interests which in fact do not coincide, such as the care of the individual patient and the national budget. They assume that medical fraud is widespread, and that policing for this fraud will be cost effective without pilot studies to prove the assumption.

Finally, logic does not demand that doctors must participate within PSRO's in order to affect them. It is as logical that doctors can affect PSRO's from without.

Lest it be overlooked, it is important to emphasize that the historical role of a physician is